

<b>MEDICAL LEGAL FEE SCHEDULE</b>	<b>RULEMAKING COMMENTS 45 DAY COMMENT PERIOD</b>	<b>NAME OF PERSON/ AFFILIATION</b>	<b>RESPONSE</b>	<b>ACTION</b>
Section 9795(c) ML 106	ML106 should read: Fees for supplemental medical-legal reports	Judi McMahan Bill Review Supervisor Gregory B. Bragg and Association Written Comment December 28, 2005	The Division disagrees with the commenter that title needs to be changed. The current title is acceptable.	No action required.
Section 9793 (a)	Commenter states that the opening definition of what constitutes a claim does not state the current law. Since the Supreme Court decision in Honeywell, a claim requires the actual filing of a claim form, or the communication to the employer of the desire to file a claim couple with an active attempt by the employer to suppress the filing. Mere “knowledge” by the employer of an “injury” was explicitly struck down by the court as being sufficient to trigger a claim. A claim is just that, a claim for benefits.	Tim Nye Written Comment January 20, 2006	The Division disagrees with the commenter that the definition is inconsistent with decisional law. The proposed amendment to the regulation did not propose any textual change to this definition.	No action required.
Section 9795 (c) Relative Value ML 103	At a minimum, payment for services of a QME under 8 CCR 9795 should be at the same level (or higher) as a non-QME billing for the same exact evaluation, e.g.: six hours at two hours each, face-to-face time, record review and research.  Currently, a primary treating physician (PTP) or consulting physician preparing a P&S report, performed and written to the same standards as the QME report and billing under OMFS, is compensated 25% to 40% higher than a QME billing for the same six hours under an ML 103. Currently an ML 103, a six hour evaluation, pays \$750. The proposed regulation increases the same six hours to	James E. Musick, D.C., QME, Chairman International Chiropractors Association of California Written Comment January 25, 2006	The Division disagrees with the conclusions of commenter. The functions performed by a PTP during six hours of time with the patient are substantially different than the functions of a QME in evaluating a patient.	No action required.

	<p>\$937.50.</p> <p>Currently, a PTP performing exactly the same six hours as a QME under an ML 103 earns \$1,027.43 (see “Example: Patient A”). The consulting physician (under L.C. 4061.5) earns \$1,144.73. These figures are well above the amount for billing under an ML 103 by the QME.</p> <p>Commenter recommends increasing the relative value on the ML 103 (at a minimum) to that equivalent of a consulting physician, as described above. A relative value of 92 times a conversion factor of \$12.50 would yield \$1,150. All other Med-legal codes are believed to be comparative and appropriate.</p>			
<p>Section 9795 (c) Procedure Description – Relative Value ML 101</p>	<p>It is not clear, from the proposed or current text, how the QME/AME is to bill for a consultation and evaluation when the patient presents (for evaluation to resolve a dispute) and it is determined that the patient is not at Maximum Medical Improvement (MMI).</p> <p>MMI is required by the <i>AMA Guides</i>, 5<sup>th</sup> edition, before an impairment evaluation can be preformed. If MMI status has not been reached, then it should be appropriate to bill for direct time in making the MMI determination. It is recommended that the MMI evaluation be considered as a med-legal evaluation for the purposes of billing under this provision.</p> <p><u>Recommendation:</u> that language to the description of ML 101 be amended as follows:</p>	<p>James E. Musick, D.C., QME, Chairman International Chiropractors Association of California Written Comment January 25, 2006</p>	<p>The Division disagrees with the commenter. The type of evaluation that commenter calls for is provided for in other provisions. The Division finds it is necessary to continue to have a classification for a “Follow-up” examination.</p>	<p>No action required.</p>

	<p>Medical-Legal Evaluation. Limited to an evaluation where the physician determines the patient is not at maximum medical improvement or a follow-up medical-legal evaluation by a physician which occurs within nine months of the date on which the prior medical-legal evaluation was performed. The physician shall include in his or her report verification, under penalty of perjury, of time spent in each of the following activities: review of records, face-to-face time with the injured worker, and preparation of the report. Time spent shall be tabulated in increments of 15 minutes or portions thereof, <u>rounded to the nearest quarter hour</u>. The physician shall be reimbursed at the rate of RV 5, or his or her usual and customary fee, whichever is less, for each quarter hour <del>or portion thereof</del>.</p>			
Section 9793(d)	<p>It is not clear that all entities that adjust workers' compensation claims are covered by this claims administrator definition. Commenter urges that the Division use a consistent and comprehensive definition of claims administrator that includes entities such as UEF, SIF, SISF and CIGA.</p>	<p>Brenda Ramirez Medical &amp; Rehabilitation Director California Workers' Compensation Institute (CWCI) Written Comment January 30, 2006</p>	<p>The Division disagrees with the commenter that not all claims entities are covered by the definition. The Division is changing the definition to make it consistent with other regulations where the definition is used.</p>	<p>No action required.</p>
Section 9795(c) ML 103 Procedure Description	<p>Commenter suggests the following revisions:</p> <p><i>... Complex Comprehensive Medical-Legal Evaluation. Includes evaluations which require three of the complexity factors set forth below.</i></p>	<p>Brenda Ramirez Medical &amp; Rehabilitation Director California Workers' Compensation Institute (CWCI)</p>	<p>The Division agrees in part and disagrees in part with the recommendation, and has changed part of the regulations to conform with part of the recommendations of the commenter. See below.</p>	<p>Some changes made to regulation - see below.</p>

	<p><i>In a separate section at the beginning of the report, the physician shall clearly and concisely specify which of the following complexity factors were required for the evaluation, and the circumstances which made these complexity factors applicable to the evaluation. <del>An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed.</del></i></p> <p><i>(1) Two or more hours of face-to-face time by the physician with the injured worker;</i></p> <p><i>(2) Two or more hours of record review by the physician;</i></p> <p><i><del>(3) Two or more hours of medical research by the physician;</del></i></p> <p><i><del>(4)</del>(3) Four or more hours spent on any combination of two complexity factors (1)<del>(3)</del>, and (2) which shall count as two complexity factors.</i></p> <p><i><del>Any</del>Complexity factor in (1), or (2), <del>or (3)</del> used to make this combination shall not also be used as the third required complexity factor;</i></p> <p><i><del>(5) Six or more hours spent on any combination of three complexity factors (1) and (2) <del>(3)</del>, which shall count as three complexity factors;</del></i></p> <p><i><del>(6)</del>(4) Addressing the issue of medical</i></p>	<p>Written Comment January 30, 2006</p>		
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	<p><i>causation to resolve a disputed issue upon written request of the party or parties requesting the report, or if a bona fide issue of medical causation is discovered in the evaluation;</i></p> <p><del>(7)</del><u>(5)</u> <i>Addressing the issue of disputed apportionment, when determination of this issue requires the physician to evaluate three or more injuries or pathologies, or the claimant's employment by three or more employers;</i></p> <p><del>(8)</del><u>(6)</u> <i>Addressing the issue of medical monitoring of an employee following a toxic exposure to chemical, mineral or biologic substance;</i></p> <p><del>(9)</del><u>(7)</u> <i>A psychiatric or psychological evaluation which is the primary focus of the medical-legal evaluation;</i></p> <p><del>(10)</del><u>(8)</u> <i>Addressing the issue of denial or modification of treatment by the claims administrator following utilization review under Labor Code section 4610 when this issue is the primary reason for the evaluation.</i></p> <p><b><u>Discussion</u></b>  Commenter recommends removing medical research as a separate factor and removing the related language in the description of ML 103. Factors for medical causation, apportionment and utilization review disputes should encompass the medical research related to those issues. If medical research remains, commenter recommends removing factors for</p>			
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	<p>medical causation, apportionment, and utilization review disputes so that two factors do not overlap.</p> <p>In the description of the ML 103 procedure, the evaluator is instructed to document citations to the sources reviewed, but the directions fail to restrict the research to medical research that is relevant to the issue in dispute and probative. As written, it appears that evaluators would not be required to document citations in the case of ML 104. The Institute recommends modifying the language for complexity factor (3) as follows: “(3) <i>Two or more hours of medical research that is relevant to the issue in dispute by the physician. The physician shall document citations to the sources reviewed, excerpts and/or summaries of the probative evidence relied upon, and the quality of the relevant research;</i>” If medical research is not removed, the Institute recommends deleting “<i>An evaluator who specifies complexity factor (3) must also provide a list of citations to the sources reviewed</i>” from the ML 103 procedure description.</p>		Comment accepted in part.	A restrictive definition of “medical research” is added, and physicians billing for medical research are required to submit citations or copies of research materials.
Section 9795(c) ML 104 Procedure Description (2) (3)	<p>Commenter recommends removing the following first sentence of (3):</p> <p><i>A comprehensive medical-legal evaluation for which the physician and the parties agree, prior to the evaluation, that the evaluation involves extraordinary circumstances.</i></p> <p><b><u>Discussion</u></b> The proposed regulations set out the factors</p>	<p>Brenda Ramirez Medical &amp; Rehabilitation Director California Workers’ Compensation Institute (CWCI) Written Comment January 30, 2006</p>	The Division disagrees. The Division finds that that the agreement of the parties in advance that an evaluation should be considered an ML 104 is sufficient to justify that level of compensation.	No action required.

	<p>that constitute the extraordinary circumstances justifying greater compensation for the evaluating physician. In subsection (2), the agreement by the parties should be eliminated because complexity “by agreement” is considerably broader than the factors to be established by the regulation, and the exceptions could defeat the underlying purpose of the rule. The “extraordinary circumstances related to the medical condition being evaluated” either exist and can be readily articulated, or they do not. As for any level of service, the complexity of an evaluation cannot be properly pre-determined in advance.</p> <p>The complexity depends on factors that arise during and as a result of an evaluation. Some primary treating physicians and evaluators refuse to proceed unless the payer agrees in advance to pay at the ML104 rate, even in the absence of extraordinary circumstances related to the claim. This unfortunate practice that results in a choice between agreeing to unfair payment or delays can be terminated by eliminating the option to agree in advance to this level of service. ML104 should be limited to evaluation reports that document the requisite factors of extraordinary service.</p>			
Section 9795(f)	<p>Commenter recommends changing the 2005 references to 2006 since amendments will go into effect in 2006.</p>	<p>Brenda Ramirez Medical &amp; Rehabilitation Director California Workers’ Compensation Institute (CWCI) Written Comment January 30, 2006</p>	<p>Comment accepted.</p>	<p>Regulation changed to show 2006 as the appropriate year.</p>





	<p>dispute about these issues is wholly irrelevant to the underlying complexity of the issue itself. Often, a well reasoned discussion of these critical issues prevents dispute and lowers costs of the claim.</p> <p>In addition, causation and apportionment have been complexity factors since the Medical-Legal Fee Schedule was created in 1993. To eliminate them at this late hour would throw revision of CCR Section 9795 back to "square one," where we stood some months ago and serves no purpose in fulfilling the Division's stated reason for this rulemaking.</p> <p>Under the subject of Complexity, CWCI also suggests that reporting physicians may be routinely billing for research that is not relevant or necessary to their report. This comment suggests that AME and QME providers routinely and regularly "game the system" to pad their bills. Such an accusation is unfounded and in today's atmosphere of panel QMEs and AMEs, appears to suggest that physicians jeopardize their standing with both the legal community and employers with abusive billing techniques. Commenter resents the inference of wrong-doing.</p> <p><b><u>Extraordinary Circumstances</u></b>  The Institute suggests that the Division remove the ability for the parties to agree in advance that a situation is sufficiently complex as to merit billing under ML 104. They argue that the complexity of a case cannot be discerned before the examination takes place, yet they support the idea that pre-</p>		<p>The Division agrees with the commenter as to the ability of parties to agree to the level of evaluation being at ML 104.</p>	<p>No action required.</p>
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	<p>existing disputes regarding apportionment, medical causation and utilization review can contribute to the complexity of a report.</p> <p>In its discussion of this topic, CWCI goes on to say, "Some primary treating physicians and evaluators refuse to proceed unless the payer agrees in advance to pay at the ML 104 rate, even in the absence of extraordinary circumstances related to the claim." They continue, "This unfortunate practice that [sic] results in a choice between agreeing to unfair payment or delays.. ." The Institute's premise is that some physicians extort higher fees from employers. This is insulting and irresponsible. The free-market concept of providing at-will services under a mutual agreement provides both sides with the flexibility necessary to find the best possible provider of that service and negotiate a suitable fee or fee structure commensurate with all the circumstances present. One need only reference the six to 12 month AME waiting lists to appreciate the tenuous nature of current access to evaluation services. To eliminate "by agreement" scheduling would be to exacerbate the difficulties and wait times.</p> <p>Certainly, CWCI's members have no issue with paying less when they can negotiate lower fees under Medical Provider Network situations. So commenter finds it extremely hypocritical and disingenuous for the Institute to suggest that the Division restrict a medical providers' ability to do the same while accusing physicians of potentially criminal activity.</p>			
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Procedure Descriptions	<p>The proposed revision of the ML-104 procedure code deletes the reference to “extraordinary circumstances” in general while retaining a reference to “extraordinary circumstances” only when there is some prior agreement with the parties. Since the amendment restricts the scope of some “extraordinary circumstances,” commenter recommends that the division also delete the reference to such circumstances in the description of that particular procedure code. This change is consistent with the Division’s statement of reasons which states that is “was necessary to delete extraordinary circumstances . . . to make more objective the determination of whether an evaluation qualifies as ML 104.”</p> <p>Under usual protocols for judicial interpretation, the heading of a particular procedure description does not supersede the language of the body of the procedure description. Nevertheless, it is wise not to create an ambiguity between the heading and the body. Accordingly, commenter suggests revising the heading of the various procedure descriptions to eliminate any possible confusion as to their scope. Commenter suggests the following:</p> <table><tr><td>Code</td><td>Procedure Description</td></tr><tr><td>ML-101</td><td>Level 1 Re-evaluation</td></tr><tr><td>ML-102</td><td>Level 2 Evaluation</td></tr><tr><td>ML-103</td><td>Level 3 Evaluation</td></tr><tr><td>ML-104</td><td>Level 4 Evaluation</td></tr><tr><td>ML-105</td><td>Level 5 Medical-Legal Testimony</td></tr></table>	Code	Procedure Description	ML-101	Level 1 Re-evaluation	ML-102	Level 2 Evaluation	ML-103	Level 3 Evaluation	ML-104	Level 4 Evaluation	ML-105	Level 5 Medical-Legal Testimony	<p>Fredric H. Newton, M.D., Chair CSIMS Medical-Legal Task Force Written Comment January 30, 2006</p>	<p>The Division disagrees with the commenter’s suggestion to change the title of the section. The Division finds that “extraordinary circumstances” remains an appropriate title for the section of the regulation.</p>	<p>No action required.</p>
Code	Procedure Description															
ML-101	Level 1 Re-evaluation															
ML-102	Level 2 Evaluation															
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ML-104	Level 4 Evaluation															
ML-105	Level 5 Medical-Legal Testimony															

	ML0160 Level 6 Supplemental Medical-legal evaluations			
Section 9495(f)	<p>Should be modified as follows:</p> <p>(f) This section shall apply to medical-legal evaluation reports where the examination occurs on or after the effective date of this section. Amendments to this section shall apply to medical legal evaluations reports where the examination to which the report refers occurs on or after the effective date of the amendments and to medical-legal testimony where such testimony occurs on or after the effective date of the amendments. The 1999 amendments to this section shall apply to medical-legal evaluation reports where the medical examination to which the report refers occurs on or after April 1, 1999, and to medical-legal testimony on or after April 1, 1999. The 2005 amendments to the section shall apply to <del>both</del>: (1) medical-legal evaluation reports where the medical examination to which the report refers occurs on or after the effective date of the 2005 amendments; and (2) medical-legal testimony provided on or after the effective date of the 2005 amendments. (3) Supplemental medical legal reports that are requested on or after the effective date of the 2005 amendments regardless of the date of the original examination.</p> <p>This section as written would exclude all Supplementals from increased reimbursement until such time as the “medical examination to which the (supplemental) report refers occurs on or after the effective date of the 2005</p>	<p>Fredric H. Newton, M.D., Chair CSIMS Medical-Legal Task Force Written Comment January 30, 2006</p>	<p>Comment accepted.</p>	<p>Text changed to make the amendments also applicable to supplemental reports.</p>

	(revisions).” Commenter believes this is an unintended consequence with repercussions that might last for years as it would create a dual billing system which will undoubtedly prove unwieldy and confusing for both providers and payors. The intent of the proposed changes to the MLFS is to increase physician compensation which has been static for 12 years. It should not matter whether the physician work product is the result of a patient interaction or a review of records. As written, 9795(f) creates an unnecessary and inappropriate dichotomy which can and should be remedied.			
General Comment	<p>Commenter thanks the Division for its efforts to address her concerns with the informal recommendations proposed by the Division late last year. As commenter has previously stated, the initial proposal would have actually decreased reimbursement rates for most Med-Legal services, even while requiring additional evaluation and reporting requirements.</p> <p>Commenter is pleased that the recommendations now being proposed are in keeping with the administrative director’s commitment to increase reimbursement in recognition of the additional work associated with AMA guidelines.</p>	<p>Nileen Verbeten Vice President California Medical Association – Center for Economic Services Written Comment January 30, 2006</p>	No change suggested and no criticism made.	No action required.
General comment	<p><b>AMEs should be reimbursed higher than QMEs.</b> For more than a decade, the system has encouraged the development of AME-level physicians. It is conferred upon a physician by agreement of both opposing sides based on a demonstration of competency, consistency, fairness and an</p>	<p>Kassie Doonoghue, DC President California Chiropractic Association Written Comment January 30, 2006</p>	<p>The Division disagrees with the commenter that the changes will reduce the use of AME's. The prior complexity factor of an evaluation by an AME was dependent on complex issues of apportionment. Apportionment as a complexity</p>	No action required.

	<p>ability to articulate a rationale. More than ever before, the system needs physicians who are considered impartial and, most importantly, have the expertise to address the issues correctly. That requires a substantial degree of experience, and experience deserves recognition and compensation.</p> <p>Elimination of the AME differential will almost certainly diminish the pool of expert QME's, especially for addressing the most complicated cases. While being a QME is not a requirement to become an AME, virtually all AMEs are QMEs. The pool of physicians willing to become QME's is down from two years ago. CCA can document that there are dramatically fewer physicians even willing taking course work to become a QME. Coupled with the reduction in the number of experienced physicians willing to even treat workers' compensation patients, a further reduction of the compensation paid to AMEs will almost certainly result in fewer QMEs.</p>		<p>factor is treated differently in the amended regulation. The Division finds that the 25% increase for use by an AME in modifier 94 is adequate additional compensation for the AME.</p>	
<p>Section 9795(c) ML 103 Procedure Description (6) (7)</p>	<p><b>Commenter opposes changes to the ML 103 criteria that would make it nearly impossible to use this code.</b> One of the complexity factors has always been the need for the evaluator to address a bona fide issue of apportionment. The proposed regulations under complexity factor number seven would require the physician to "evaluate three or more injuries or pathologies, or the claimant's employment by three or more employers." This is a greater threshold to meet than the current standard. Apportionment has always been a complicated business and the subject of dozens of court decisions to arrive at generally</p>	<p>Kassie Donoghue, DC President California Chiropractic Association Written Comment January 30, 2006</p>	<p>The Division disagrees that the changes will make it almost impossible to use the ML 103. The Division finds that the analysis of apportionment in most cases will be minimal.</p>	<p>No action required.</p>

	<p>accepted base for proper apportionment. All that was thrown out two years ago, and as a result <u>all</u> apportionment is complicated now and subject to dispute. There is no justifiable reason to penalize doctors who do med-legal reports by raising more hurdles to get paid the same amount for addressing even more complicated apportionment.</p> <p>Furthermore, the proposed regulations under complexity factor number six force the party requesting the report to ask the QME to address causation if ML 103 is to be used. Under Labor Code 4663, all physicians must address causation so this is an unnecessary requirement that will only serve to prohibit the use of this code in many cases. Injured workers are often the party requesting the report in the case of a panel QME and they will likely not be aware of this new requirement to ask for the QME to address causation.</p> <p>Public interest is served by having physicians willing to provide a knowledgeable and thorough analysis of apportionment. Human nature being what it is, removing incentive to provide what is often difficult and complex is likely to result in less thoughtful, complete or defensible reports. In the end, it's the injured worker that suffers – even more.</p>			
Section 9795 General Comment Complexity Factors	<p>Commenter appreciates that the Division acknowledges the extra analysis required by the AMA guidelines and the additional work required by proposing an across-the-board increase in the value of the multiplier.</p>	<p>Peter Mandell, M.D., Chair – Workers' Compensation Committee California Orthopaedic Association Written &amp; Oral</p>	<p>The Division disagrees with the commenter about evaluations of several body parts or the hand, and does not find that these evaluations are substantially more complex than some other evaluations.</p>	<p>No action required.</p>

	<p>Commenter continues to urge the Division to add additional complexity factors allowing musculoskeletal evaluations involving several body parts or complex hand evaluations to be reimbursed as a ML103 or ML 104 evaluation. Without these changes, numerous musculoskeletal evaluations will likely not be able to meet the criteria of an ML103 or ML104 evaluation. Without these additional complexity factors, commenter believes that QMEs/AMEs will resist taking on the challenge of these complex cases due to the effort and the time involved in these evaluations. Access will be limited.</p> <p>Commenter has heard no one dispute that when there are multiple body parts injured or severe hand injuries involving several digits, the complexity of the evaluation is considerably more complex and time-consuming under the AMA Guides than the prior disability evaluation system.</p> <p>Commenter urges the Division to reconsider the following additional complexity factors for ML103.</p> <p><b>ML103 (11)</b> – <u>“An evaluation of the hand involving 2 or more injured digits.”</u></p> <p>This language would allow hand injuries involving 2 or more digits (fingers or thumb) to count as an additional complexity factor.</p> <p><b>ML 103 (12)</b> - <u>“A physical evaluation involving multiple injured body parts. Separate musculoskeletal injured body parts</u></p>	<p>Comments January 30, 2006</p>		
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	<p><u>are defined as:</u></p> <ul style="list-style-type: none"> <li>• <u>Cervical/Thoracic Spine</u></li> <li>• <u>Thoracic/Lumbar Spine</u></li> <li>• <u>One or both Shoulders and/or Elbows and/or Wrists</u></li> <li>• <u>One or both Hips</u></li> <li>• <u>One or both Knees</u></li> <li>• <u>One or both Ankles</u></li> <li>• <u>Right Foot/Toes</u></li> <li>• <u>Left Foot/Toes</u></li> </ul> <p><u>For a body part to be considered a separate body part, it shall have intrinsic injury/pathology and not simply be the locus of referred symptoms and/or radiculopathy from another injured/diseased body part as defined in these regulations. Add one complexity factor for each injured body part beyond the first two.”</u></p> <p>This language would not only define separate body parts, but rein in potential abuse by stating that referred symptoms and/or radiculopathy would not be sufficient to be considered a separate body part. Also, measurements of the same body part, e.g., shoulder, hip, knee, or ankle, would not count as a second body part.</p> <p>Apart from the above recommendations, commenter believes that the Division’s proposed new Medical-Legal Fee Schedule will serve the interests of California’s employers and workers well. We oppose changes that:</p> <ul style="list-style-type: none"> <li>• Remove 2 or more hours of research</li> </ul>			
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	<p>as a complexity factor.</p> <ul style="list-style-type: none"> <li>• Remove 6 or more hours spent on any combination of three complexity factors.</li> <li>• Alter language about addressing issues of medical causation and apportionment.</li> <li>• Alter addressing the issue of denial or modification of treatment.</li> <li>• Alter the ability to allow the physician and the parties to agree in advance on what the ML exam level should be.</li> </ul>			
General Comments	<p>As noted in the “Initial Statement of Reasons” issued by your Division, fees for medical-legal evaluations have not been increased since August, 1993. Furthermore, as described in the “Initial Statement of Reasons,” the evaluations and reports that are covered by this fee schedule are considerably more complex and time consuming than in prior years. Given these facts – a stagnant fee schedule and increased demands on time and expertise – it is no surprise that physicians are electing not to participate in this process. According to the “Initial Statement of Reasons,” since the enactment of SB 899 the number of QMEs has dropped 11.6%. And alarmingly, this decrease may be only the tip of the iceberg, as the number of physician applicants for the QME examination has plummeted by 64%.</p> <p>Commenter strongly urges the Division to look into the problems uncovered in a recent survey of physicians by the California</p>	<p>Mark Gerlach, Consultant California Applicant’s Attorneys Association (CAAA) Written and Oral Comments January 30, 2006</p>	<p>Much of this commenter’s comments do not relate to proposed changes in the fee schedule.</p>	<p>No action required.</p>

	<p>Medical Association. The mushrooming problems described in the CMA's report, including improper delays under utilization review and the misapplication of treatment guidelines, are putting unnecessary pressure on the dispute resolution process. If physicians continue to drop out of the system, we will quickly face a major crisis. Commenter believes that many of the problems uncovered by the CMA can be resolved by the adoption of a clearly defined regulatory rules and penalties, and he urges prompt attention to these issues.</p> <p>Commenter strongly supports the proposed increase in medical-legal fees; however, he believes that this proposal represents the bare minimum increase that is needed to provide evaluating physicians with fair compensation.</p> <p>Commenter believes the regulations should provide an increased incentive for physicians to participate as Agreed Medical Evaluators and that all parties benefit when a single evaluator is agreed upon. Commenter states that in many parts of the state there are currently so few physicians willing to serve as an AME that it takes a minimum of 6 months to get an appointment with a selected physician. Commenter states that this delay is particularly harmful to injured workers, who are now subject to a 104 week limitation on their temporary disability benefits and that these delays do not help the employer or insurer either.</p> <p>Commenter states that the current medical-</p>		<p>The Division disagrees that additional incentive in these fees is necessary to encourage more physicians to serve as AME's. The Division finds that the increased compensation to modifier 94 is adequate additional payment to AME's.</p>	<p>No action required.</p>
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	<p>legal fee schedule provides for a 25% modifier when an evaluation is performed by an AME. However, commenter believes that in order to provide increased incentive to physicians to become agreed medical evaluators, that this modifier be increased to at least 35%.</p>			
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